Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GARLAND COMMUNITY HOSPITAL
C/O LAW OFFICE OF P MATTHEW ONEILL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729

Respondent Name

HARTFORD UNDERWRITERS INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-98-5569-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC's interpretation, the bills for acute in-patient treatments provided after December 6 1995, may be resubmitted to the insurance carriers for payment under the Texas Workers' Compensation Act. This means that those bills need to be paid at the usual and customary rates under the Texas Labor Code rule #413.011, which, historically, has been 96% of the charges in our case… we hereby request you to pay us our bill at the usual and customary rate, disregarding the Fee Guidelines. "

Amount in Dispute: $11,912.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response for consideration in this dispute.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 1997 to August 2, 1997	Inpatient Hospital Services	$11,912.98	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the fee guidelines for acute care inpatient hospital services.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on October 14, 1997.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F – SUBMITTED SERVICES WERE REPRICED IN ACCORDANCE WITH STATE PER DIEM GUIDELINES.
   - F – SUBMITTED SERVICES ARE CONSIDERED INCLUSIVE UNDER THE STATE PER DIEM GUIDELINES.
   - F – REIMBURSEMENT ACCORDING TO THE TEXAS MEDICAL FEE GUIDELINES.

Findings

1. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include a copy of medical records to support the services as billed or other written communications and memoranda pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).
2. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264. Review of the submitted documentation finds that the length of stay was 10 days. The type of admission is surgical; therefore, 10 total days minus 1 ICU day equals 9 surgical days. 9 days at $1,118 plus 1 day at $1,560 yields a reimbursement amount of $11,622.00.
3. Additionally, per §134.401(c)(4)(A)(i), implantables (revenue codes 275, 276, and 278) shall be reimbursed at cost to the hospital plus 10%." Review of the submitted medical bill finds that, although the health care provider billed revenue code 278 for supply/implant services, no medical documentation was found to support the services as billed. Additional reimbursement cannot be recommended.
4. Additionally, per §134.401(c)(4)(B) (iv), when medically necessary blood services indicated by revenue codes 380-399 shall be reimbursed at a fair and reasonable rate. Review of the submitted medical bill finds that, although the health care provider billed revenue code 380 for blood services, no medical documentation was found to support the services as billed. Additional reimbursement cannot be recommended.
5. The total recommended reimbursement for the services in dispute is $11,622.00. This amount less the amount paid by the insurance carrier of $23,094.50 leaves an amount due to the requestor of $0.00. No additional payment is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	January 31, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.